# Breathing Matters

A Biannual Newsletter from the Respiratory Care Board

FALL 2005


## Board Completes Home Respiratory Care Review

In 2001, the Respiratory Care Board of California (Board) underwent a review by the Joint Legislative Sunset Review Committee (JLSRC) and noted its concern for the lack of regulatory oversight for respiratory care provided in the home. In response, the JLSRC supported the Board's effort to review the function and skill of currently unlicensed technicians. The JLSRC also supported further study to determine the need to regulate these technicians. This article summarizes the Board's findings.

In its initial review, the Board has found home care and the home use of sophisticated medical devices by unqualified caregivers to be a growing trend. As a result, patient safety and the clinical effectiveness of medical devices, as they pertain to respiratory care, has declined, jeopardizing respiratory patients' health, safety, and welfare.

*"In its initial review, the Board found home care and the home use of sophisticated medical devices by unqualified caregivers to be a growing trend. As a result, patient safety and the clinical effectiveness of medical devices, as they pertain to respiratory care, has declined, jeopardizing respiratory patients' health, safety, and welfare."*

Many sophisticated medical devices used for respiratory care, such as ventilators, continuous positive airway pressure devices, respiratory disease management devices, apnea monitors, and low air loss continuous pressure management devices, require extensive education and instruction, or the consequences can be detrimental. The use of these respiratory care devices is governed by the Respiratory Care Practice Act and requires licensure as a respiratory care practitioner, other qualified licensed personnel, or by a person exempted from the Act. Self-care by the patient or the gratuitous care by a friend or member of the family is one of those exemptions.

Personnel entering homes in support of the home care patient include respiratory care practitioners (RCPs), registered nurses (RNs), vocational nurses, home health aides, and other non-licensed personnel including equipment delivery personnel. There is a vast range of education and experience among these personnel, from people having no familiarity with patient care and/or medical equipment to those that have been educated, trained, and competency tested in patient care and sophisticated respiratory equipment.

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## Board Meeting and Strategic Planning Session

The Respiratory Care Board is scheduled to meet and conduct strategic planning on Monday, November 14, 2005 in the Los Angeles/Burbank area. All meetings are open to the public, and the Board welcomes and encourages your attendance!

Please visit the Board's website at www.rcb.ca.gov for more information on meeting dates, times, and locations. Agendas for upcoming meetings are posted 10 days prior to meeting dates.

## Inside this issue...




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*The Respiratory Care Board of California's mandate is to protect the public from the unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care. Protection of the public shall be the highest priority for the Respiratory Care Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.*

## President's Message

Larry L. Renner, BS, RRT, RPFT, RCP
President

These past few weeks the nation has been focused on the devastation caused by Hurricane Katrina in the states of Louisiana, Alabama and Mississippi. It is difficult to see the thousands of individuals and families left with nothing after this Category 5 hurricane ripped through these gulf coast communities. As a result of these tragedies, many respiratory care professionals have been left both homeless and jobless for an unknown period of time. Because of that, we expedited the licensure process for those respiratory care professionals impacted by this devastation. Should you know of respiratory care practitioners from these gulf states who are in need of employment, have them contact the Board's office immediately.

In addition, the American Association for Respiratory Care (AARC) also sent out a call for respiratory care practitioners to care for hurricane victims at temporary medical sites. These sites will be located in New Orleans and in the surrounding gulf coast communities. From what we all have seen, the need for health care and the expertise of respiratory care professionals will be needed for an extended period of time. If you can help, or would like additional information, contact the AARC directly to find how your services can be utilized.

Despite the devastation, the Board has continued with its strategic objectives and its committee work to improve the profession and advance consumer safety. As a result of this work, I have excellent news regarding legislation that will impact the Board's effectiveness with the licensure process. As I am writing this President's Message, three bills (SB 229, SB 232 and SB 1111) have all passed the California Assembly and Senate. The next step will be the enrollment process where the Governor is expected to sign them into law. Assuming all of this takes place, we will finally have an official one year extension for our Sunset Review process. As you may remember from the last newsletter, this process stalled when the Governor proposed his plan to eliminate 88 boards and commissions. In addition, the proposed amendments clarify the examination process by giving the Board more flexibility to address changes and improve the examination processes and procedures. We also will have established a change to increase the overall efficiency of the reinstatement process.

Future work for the Board includes a strategic planning session which has been scheduled in conjunction with the November Board Meeting. This session will provide an opportunity for the Board to reevaluate its priorities inline with its vision. It will create a road map to guide the Board as it pursues its top priorities facing the profession of respiratory care in the interest of consumer protection.

## Farewell to Kim Cooper Salinger, MBA, RRT Exemplary Board Member


Kim Cooper Salinger, MBA, RRT

In mid-July, the Respiratory Care Board (Board) bid a fond farewell to its Vice President, Kim Salinger, following successful completion of her term as a member of the Board. While Ms. Salinger was eligible for reappointment, she admirably chose to scale back professional activities, dedicating her time and attention to her young daughter.

Ms. Salinger was appointed to the Board by the Speaker of the Assembly in 2002. Having worked in various patient care settings at medical centers in Arizona, Oregon and California, Ms. Salinger brought a wealth of knowledge with her to the Board. Her experience, coupled with her unyielding dedication, immediately made her an integral component of the Board. During her appointment, Ms. Salinger worked diligently in a variety of capacities, including her most recent role as Vice President and as a member of the Education Committee.

Ms. Salinger made significant contributions on a number of issues that required her commitment, dedication and active participation. This resulted in new laws and regulations aimed at improving consumer protection. Her knowledge, experience, and interest in education were instrumental in the early development of the Board's upcoming Law and Professional Ethics course. She was a catalyst in establishing the Board's education waiver process, and she assisted in strengthening rules governing the evaluation of foreign and continuing education.

Whatever the challenge or endeavor, Ms. Salinger could always be relied upon to work diligently toward the enhancement of consumer protection. She never wavered in her commitment or dedication as a member of the Board, as displayed by her involvement with various professional associations and her participation in local community activities.

While members and staff will sincerely miss Ms. Salinger and her unyielding dedication to the Board and its mandate, they wish her many successes in all her future endeavors!

## *Respiratory Care Board Responds to Hurricane Katrina*

***In response to the recent devastation caused by Hurricane Katrina, the Board has been expediting application processing and the issuing of work permits for displaced respiratory therapists that have temporarily or permanently relocated to California. The Board has also received an outpouring of concern from licensees, many of whom have expressed their desire to volunteer with relief efforts. For more information regarding the activities and involvement of the respiratory community in Hurricane Katrina relief efforts, or to find out how you can help, please visit the AARC's website at www.aarc.org.***

## New Website Feature . . . E-Mail Updates

The Board recently established an e-mail service to provide updates including meeting agendas, advisory notices and special bulletins. Anyone can subscribe to this free service by visiting the Board's web site and clicking on the link entitled "Join our Mailing List." Sign up today to begin receiving updates from the Board!

## Renew Your License Early!

To ensure you receive your new license before the old one expires, the Board encourages licensees to renew as soon as their license renewal application is received.

License renewal applications are mailed to the last address of record approximately 75 days prior to expiration. All applications for renewal are required to be sent directly to the Department of Consumer Affairs' Automated Cashiering Unit for processing.

The Automated Cashiering Unit processes renewal applications for all boards and bureaus within the Department. It may take 10-15 days to post the receipt of a license renewal after the application has been received. Unfortunately, the Board is unable to confirm receipt of a license renewal application until it has been posted to the licensing record by the Automated Cashiering Unit.

Once a renewal is posted, provided the licensee has complied with all renewal requirements, the renewed license is generally mailed within 5 working days. However, the renewal process will be substantially delayed if the renewal application is deficient.

The most common cause for delay is the omission of information on the renewal application. To avoid a delay, carefully read the renewal instructions and be sure your renewal application is complete.

Remember, if you fail to renew your license on or before your expiration date, or if your renewal is deficient and is not rectified prior to your expiration date, you cannot practice respiratory care in the State of California until all renewal requirements have been met.

Employers are always encouraged to verify the status of all Respiratory Care Practitioner licenses. License verifications can be obtained online at www.rcb.ca.gov or by contacting the Board via e-mail at rcbinfo@dca.ca.gov.

## NATIONAL RESPIRATORY CARE WEEK
## October 23 - 29, 2005

Respiratory Care Week is that time of year when we honor and celebrate the contributions of respiratory therapy to lung health. It is a week-long event to demonstrate pride in the profession and in the individual accomplishments of respiratory therapists throughout the world. It is also an excellent opportunity to showcase the role of respiratory therapists in the nation's health care system, educate others, recruit new students into the rapidly growing profession, and to promote lung health awareness in the community.

## Did You Know?

Have you ever wondered where applicants for licensure first hear about the respiratory care profession? Following the implementation of various outreach efforts, the Board's application for licensure was revised in 2003 to include the following optional question, "Where did you first learn about the respiratory care profession? (Please check all that apply)"

Out of 695 applicants who responded in FY 04/05, 748 responses were given as follows:

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|---|---|---|
| Career Fair | 16 | 2% |
| High School | 31 | 4.5% |
| Personal Experience | 219 | 32% |
| College | 266 | 38% |
| Other* | 216 | 31% |

*Most noted a family member or friend had informed them.

## We Want to Hear from You

If you have issues, concerns or ideas you think would better serve the consumers of California or the respiratory care profession, we want to hear from you. E-mails can be addressed to rcbinfo@dca.ca.gov.

## Board Completes Home Respiratory Care Review (CONTINUED FROM PAGE 1)

Currently in California, home care regulation is limited to Home Medical Device Retail Facilities (HMDRFs) and Home Health Agencies (HHAs). Neither component recognizes the need for formal education, training and competency testing as it pertains to respiratory care and the use of respiratory medical devices.

There are an estimated 3,600 HMDRFs regulated by the Department of Health Services (DHS) in California. According to Health & Safety Code, section 111635, the department shall conduct inspections "to determine ownership, adequacy of facilities, and personnel qualifications." Because licensure of HMDRFs stops at instruction in use of equipment, there is no requirement to evaluate competency or consider personnel qualifications as they relate to the care or well being of the patient. Instead, inspections of "personnel qualifications" are limited to showing evidence that an employee has been "trained" to understand the operation of the device. Generally, evidence of "training" consists of a certificate of completion from either an in-service session or manufacturer's course on specific equipment.

*"There are also numerous reports of fraud emerging, specifically that HMDRFs are ordering additional tests without a physician's order and billing for excessive and unnecessary equipment."*

However, during scheduled inspections, the HMDRF unit has been working with the Board by investigating complaints of unlicensed practice. Several HMDRFs are employing equipment delivery personnel to perform patient care, including ventilator checks, diagnostic tests and medication delivery. Equipment delivery personnel are not qualified or authorized to perform any type of clinical assessment or care. There are also numerous reports of fraud emerging, specifically that HMDRFs are ordering additional tests without a physician's order and billing for excessive and unnecessary equipment. Many HMDRFs have been using equipment delivery personnel to conduct these respiratory diagnostic tests, which become the basis for renting additional equipment.

Unlike HMDRFs, HHAs are mandated to provide patient care. The Board believes that regulation of "patient care" has made the unsafe practice of respiratory care less prevalent among Home Health Agencies. The most common complaint received regarding HHAs is that the staff are not familiar with respiratory medical equipment and are not educated to respond to unusual situations. Furthermore, staff are not educated or trained to use the medical equipment in a way that allows the patient to receive the most beneficial treatment. HHAs are required to have an RN, or occupational, physical, or speech therapist oversee all treatment plans (within each professional's scope of practice). Generally, an RN will oversee the treatment plan of a patient with respiratory ailments. Yet presently, care is being performed by LVNs, home health aides, or "other non-licensed personnel."

Another factor to consider is the dispensing of oxygen cylinders, one of the most frequently dispensed devices. There are reports that drivers are delivering oxygen cylinders improperly, such as placing tanks next to gas pilot lights. Although the handling of oxygen does not require a licensed professional, the HMDRF must ensure that the personnel handling oxygen are trained. Again, nothing more than a certificate of completion is needed for purposes of regulation. Licensed professionals (i.e. RCP, RN, LVN) receive formal education and training on the handling of hazardous materials. Medical gas mix-ups and the improper handling of oxygen have caused unnecessary fatalities and generated several warnings.

The Board is mandated to protect the public from the unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care. It is further mandated that "protection of the public shall be the highest priority for the Respiratory Care Board of California in exercising its licensing, regulatory, and disciplinary functions." In accordance with its mandates, the Board makes the following recommendations:

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## Board Completes Home Respiratory Care Review (CONTINUED FROM PAGE 5)

• Respiratory Care Practice Act Proposed Amendments
The Board recommends pursuing legislative amendments necessary to implement exemption regulations as a means to provide guidance to the home care industry of what services a "delivery driver" or other unlicensed personnel may perform and under which criteria, as it relates to respiratory care and respiratory care related services. The regulations will also provide specific and needed direction for Home Medical Device Retail Facilities and Home Health Agencies.

As proposed, persons not otherwise authorized or exempt to provide respiratory care services, will be permitted to perform the following limited and basic respiratory care or respiratory care related services in the home setting or for the purposes of patient transfer to the home setting, provided the following conditions are met:

- The person provides services through his/her employment with a Home Medical Device Retail Facility or Home Health Agency licensed by the California Department of Health Services (or subsequent regulatory name and/or agency);

- Initial training, ongoing in-service education, and periodic competency testing specific to each service and equipment-type is provided by either a California licensed respiratory care practitioner (as appropriate to the specific training, in-service and testing) or other qualified licensed personnel (HMDRF Exemptee) and documentation of such training, education and testing is maintained for a period of four years.

- Each patient or caregiver, as appropriate, is advised prior to or at the time equipment or supplies are delivered, and such services are provided accordingly, that a licensed respiratory care practitioner or other qualified licensed personnel of the equipment provider shall provide follow up checks, by telephone or in-person as appropriate, at the request of the patient, the patient's physician, the patient's caregiver, or any person who has had contact with the patient, or as otherwise directed by a plan of care.

**Respiratory care and respiratory care services as they relate to:**

* Positive airway pressure (with or without a back-up rate) devices and supplies;
* Intermittent positive pressure breathing devices and supplies;
* Ventilatory devices and supplies;
* Nasotracheal or tracheal suctioning devices and supplies;
* Apnea monitors and alarms and supplies;
* Tracheostomy care devices and supplies;
* Respiratory diagnostic testing devices and supplies, including but not limited to pulse oximetry, CO2 monitoring, and spirometry devices and supplies, and
* Pulse-dose type or demand conserving oxygen delivery devices or high flow oxygen systems beyond the capabilities of a simple mask or cannula or requiring particulate or molecular therapy in conjunction with oxygen.

Unlicensed personnel ***would be <u>permitted</u> to:***

✓ Deliver equipment and supplies, and
✓ Instruct the patient or the patient's family or caregiver(s) on how to order equipment and sup plies and where to call, 24 hours a day, 7 days a week, in case of emergency.

Unlicensed personnel ***would be <u>prohibited</u> from:***

✗ Setting up equipment;
✗ Providing any instruction to the patient or patient's family or caregiver(s) as it relates to the operation or use of the equipment, clinical application of the equipment and/or supplies;
✗ Performing any level of clinical assessment of the patient;
✗ Touching the patient for the purposes of making an assessment or placing any device upon the patient, and
✗ Any other interaction with the patient or the patient's family or caregiver(s) that is related to equipment and/or supply delivery or re-order, or the instruction of where to call in case of an emergency.

**As it relates to oxygen delivery systems and pre-filled cylinders, excluding pulse-dose or demand conserving oxygen systems and high flow oxygen systems beyond the capabilities of a simple mask or cannula or requiring particulate or molecular therapy in conjunction with oxygen.**

Unlicensed personnel ***would be permitted to:***

- ✓ Deliver equipment and supplies;
- ✓ Instruct the patient or the patient's family or caregiver(s) on how to order oxygen equipment and supplies and where to call, 24 hours a day, 7 days a week, in case of emergency;
- ✓ Instruct the patient or the patient's family or caregiver(s) in the proper and safe operation of oxygen equipment including: equipment set-up; connecting disposable tubing, cannulas, and masks; verification of oxygen flow; demonstration to the patient of prescribed flow rate(s); connection and cleaning of oxygen humidifying equipment and devices; use of portable back-up oxygen cylinders and equipment, and removal and disposition of disposable tubing, cannulas, and masks, and
- ✓ Conduct regular in-home evaluations and gather information from the patient and home setting pertaining to the set-up, instruction, and provision of information as described in this subdivision for the use of the prescribing physician.

Unlicensed personnel ***would be prohibited from:***

- ✗ Direct administration of home oxygen;
- ✗ Handling or adjusting home oxygen equipment while it is in use by the patient or on the patient;
- ✗ Touching the patient or placing any device upon the patient while engaged in the set-up and instruction of equipment, including performing an oximetry evaluation or oxygen saturation test;
- ✗ Directly engaging in any changes of the set-up, instruction or use of oxygen or explanation of therapy, clinical care plans, prescribed equipment and/or clinical applications, and
- ✗ Any other interaction with the patient or the patients' family or caregiver(s) that is related to equipment and/or supply delivery or re-order, or the instruction of where to call in case of an emergency.

**As it relates to any other respiratory care equipment and supplies not identified above.**

Unlicensed personnel ***would be permitted to:***

- ✓ Deliver equipment and supplies;
- ✓ Instruct the patient or the patient's family or caregiver(s) on how to order equipment and supplies and where to call, 24 hours a day, 7 days a week, in case of emergency;
- ✓ Set up equipment, and
- ✓ Provide instruction to the patient or the patient's family or caregiver(s) of the mechanical operation of the equipment or the general use of equipment or supplies.

Unlicensed personnel ***would be prohibited from:***

- ✗ Performing any level of clinical assessment of the patient;
- ✗ Providing any instruction to the patient or the patient's family or caregiver(s) as it relates to the operation or use of the equipment for the purpose of deriving the intended medical benefit or clinical application of equipment and/or supplies;
- ✗ Directly engaging in any discussion of clinical care plans, therapy, prescriptions, or clinical application;
- ✗ Touching the patient or placing any device upon the patient while engaged in the set-up and instruction of equipment, and
- ✗ Any other interaction with the patient or the patients' family or caregiver(s) that is related to equipment and/or supply delivery or re-order, or the instruction of where to call in case of an emergency.

The proposed regulations will also provide clarification and give notice for anyone practicing respiratory care through an exemption of their obligations to provide information to the Board and actions the Board can take should one exceed the purview or requirements for the exemptions provided.

• Home Medical Device Retail Facility Act

The Board recommends the DHS be given broader regulatory control over HMDRFs who dispense respiratory equipment and/or supplies, require those HMDRFs to hold national accreditation, employ qualified licensed personnel, and notify caregivers and make available 24 hour access to qualified personnel.

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## Board Completes Home Respiratory Care Review (CONTINUED FROM PAGE 7)

• Home Health Agency Act

The Board recommends legislative amendments to 1) clarify that a licensed HHA may provide or arrange for respiratory services (as is currently done), and 2) provide licensed RCPs as an additional type of licensed personnel that can provide supervision of personnel. This would allow HHAs more options in providing optimum care for their respiratory care patients. The proposed amendments do not provide for additional services or costs, but rather provide the ability to use the expertise of a respiratory care practitioner in the plan of treatment when it is within the respiratory care scope of practice.

• Reimbursement

The Board recommends that serious consideration be given to establish provisions for the reimbursement of follow-up patient assessments made through HMDRFs. Currently, HMDRFs are reimbursed for specific types of equipment delivered. Reimbursement for the freight, delivery, transportation, installation, setup and instruction in the use of equipment, and repair, maintenance or routine servicing is inclusive in these flat rates.

The Board believes that providing reimbursement for follow up assessments made by qualified licensed personnel could provide significant savings in health care costs through shorter rental periods and fewer emergency room visits and hospital readmissions.

To view or obtain a full copy of the Board's Home Respiratory Care Review Report, including the actual proposed statutory and regulatory language, please visit our website at www.rcb.ca.gov/homecarereview.htm.

## License Verification Available Online!

**You can verify licensure status online via the Board's website at www.rcb.ca.gov.**

**The online license verification system is available 24 hours a day, 7 days a week and records are updated daily (M-F).**

## Respiratory Care In California DVD Available!

The Respiratory Care Board is pleased to have available its outreach DVD entitled Respiratory Care in California. The DVD was developed by the Board, and includes a wealth of detailed information, including historical facts, employment outlook, and the licensing process.

If someone you know is interested in the profession and would like a copy of the DVD, please ask them to contact the Board toll free at (866) 375-0386 or visit its website at www.rcb.ca.gov and click on the Career in Respiratory Care link.

## Healthcare Staffing Services Receive Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Certification

Personnel shortages often force healthcare organizations to fill positions with temporary employees provided by staffing firms which are not subject to any quality oversight mechanism.

In response, JCAHO launched it's Health Care Staffing Services Certification Program in October 2004 to meet quality oversight needs that have arisen due to the ongoing shortages of healthcare personnel.

JCAHO has awarded a Healthcare Staffing Service Certification to several California healthcare staffing firms. These firms participated in independent and thorough JCAHO evaluations, and they have met national standards addressing the qualifications, competency, placement and monitoring of their staff.

To view a list of all California healthcare staffing services that have been awarded Joint Committee certification, please visit JCAHO's website at http://www.jcaho.org/dscc/hcss/hcsc_orgs.htm.

## Continuing Education Requirements

Each licensee is required to complete 15 approved continuing education (CE) units in order to renew his/her respiratory care practitioner license with an active status.

The Board has found that many licensees are unaware that at least two-thirds of their required CE hours must be directly related to the clinical practice of respiratory care. This means that at least ten (10) of the CE hours completed each renewal cycle must be directly related to clinical practice, while the other five (5) can be related to other non-clinical aspects of the profession.

If a licensee takes a course that is not directly related to clinical practice, the maximum number of hours which can be applied to his/her CE requirement is five (5), regardless of how many hours he/she may have been awarded for completing the course.

To ensure compliance with CE requirements, the Board routinely conducts CE audits and selects random licensees required to participate as part of licensure. Licensees selected to participate are required to submit copies of CE certificates for each course reported during their last license renewal. The certificate(s) must include the licensee's name, license number, the name and address of the course provider, the course date, title, the number of CE hours awarded, and the course approval identifying information.

Licensees who do not meet the CE requirements are subject to a citation and fine. In addition, their licenses could be inactivated, prohibiting the practice of respiratory care until the matter is resolved. If licensees are placed on an inactive status and they continue to practice respiratory care, they may also be subject to disciplinary action and additional fines for any period of unlicensed practice.

If you are unsure of whether or not a course meets the specified criteria, or if you have other questions regarding CE requirements, please visit the Board's website at www.rcb.ca.gov and click on the Continuing Education link where you will find all CE related regulations.

## Frequently Asked Continuing Education Questions

*How long must I retain my CE documentation?*
Licensees, as well as providers, are required to maintain proof of completion for CE courses for a period of 4 years. Proof of completion includes identification that each course was provided or approved by a Board recognized organization.

*Do I need CE for my first license renewal?*
Yes. You are required to complete CE for your first license renewal. However, the number of CE's required is prorated based upon the number of months for which your initial license was granted. Information regarding the number of CE's you are required to complete was provided with your initial license information. If you are unsure of how many CE's you need, please contact the Board's office.

*What is my time frame for earning CE?*
CE must be earned in the two years preceding your license expiration date. For example, if your license expires on October 31, 2005, then approved CE earned between November 1, 2003 and October 31, 2005 can be applied toward license renewal.

*Do I submit documentation with my renewal form?*
No. If you are renewing your license on an active status, you are required to indicate the number of CE hours you earned on your license renewal. The renewal application must then be signed, under penalty of perjury, attesting to the number of approved CE's you completed. Your certificates must be submitted only when you are selected to participate in a random CE audit.

*How do I find out which CE courses and/or providers are approved?*
If you are unsure of whether or not a course meets the Board's specified criteria, please visit the Board's website at www.rcb.ca.gov and click on the Continuing Education link where you will find all CE related regulations.

*Can I get an extension on my license renewal if I have not completed my required CE hours?*
No. There is no provision in the law to allow for an extension on a license renewal. The only options would be to renew as inactive or become delinquent until the CE is completed. Keep in mind that you cannot practice respiratory care with an inactive or delinquent license.

# Scope of Practice Inquiries and Responses

*Inquiry:* I oversee a respiratory care medical center, and the RT Medical Director over me has written a weaning protocol that I disagree with. He has indicated in the weaning protocol for the RT to ask the nurse to give a patient sedation. I disagree with that. It is the province of the doctor to ask or order the nurse to give sedation, not the RTs. Do you agree with me?

*Response:* I have seen several protocols where it is appropriately written for interaction to occur between disciplines caring for a patient on a ventilator. Since nursing and respiratory usually have this type of relationship established, your question may be one of semantics and not one of a practice concern. An example of this might be when sedation has been withheld from a patient to accomplish a weaning trail. In this case, it would be appropriate for the RT to let the nurse know when the trial has been completed so that sedation could be restarted.

In my opinion, as long as the sedation order has already been written by the physician outlining the route, dose, frequency and specific pain/sedation criteria, there should not be an issue of having the RT collaborate with the nurse regarding sedation administration. If the order is not written, it would cause me to have concerns about the relevance of the protocol. However, without seeing a copy of the protocol in question, any additional comment would just be speculation.

I hope this offers you some information that can assist you and your medical director in reaching a common ground to ensure that the best care will be provided to your patients. This letter, however, is in no way intended to render an opinion concerning the scope of practice of the registered nurse who may be involved in such a procedure.

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*Inquiry:* I've been told that according to "regulation," only an RN may monitor a patient post administration of moderate sedation and analgesia.

My question concerns this "regulation." Respiratory Therapists at the medical center where I am employed administer moderate sedation for a bronchoscopy procedure. Is there a regulation that prohibits the therapist from monitoring the patient until discharge criteria are met? Are you aware of the regulation I speak of and where I can find the specifics? Is it within our scope of practice to monitor a patient post moderate sedation administration?

*Response:* I am not aware of a regulation that states only an "RN" can monitor a patient post administration of moderate sedation and analgesia. I could not find any regulation or legislative statute that indicates such a regulation exists.

It continues to be the position of the Board that it is within the scope of practice of a licensed and appropriately trained RCP to administer and assess moderate sedation to patients in either emergent or diagnostic environments. These environments are generally cardiopulmonary in nature but there is some overlap between cardiopulmonary and other diagnostic procedures (Endoscopy Services).

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*Inquiry:* In our hospital, because of JCAHO standards to improve the pharmacist validation process of respiratory medications, a recent memo was issued:

- Respiratory medications will be dispensed in the patients' cassettes.
- New orders will be processed by pharmacy and initial doses will be sent and placed in the pharmacy delivery bin.
- Cassette access is limited to pharmacy and nursing personnel.
- Respiratory therapists will need the cooperation of nursing to obtain respiratory medications from the patient cassette and the delivery bin.
- Only those medications that are going to be immediately administered may be removed from the cassette at one time.
- Normal Saline O.9% INH will be dispensed via distribution.

The concern I hope the board takes up is the respiratory therapists' access to respiratory medications in patients' cassettes, without going through nursing personnel. Pharmacy stated, since we are not allowed to give other medications in patients' cassettes, nursing must obtain our medications for us. We are licensed professionals. Pharmacy techs have access, but we do not. It doesn't seem valid. Even if the medications are delivered on time, I foresee this causing delay in service to patients, imposing more time constraints on the nurses and increasing the opportunity for negative outcomes . Our medications used to be kept locked in medical carts, and dispensed through the department. I understand the need for control on medications and Pharmacy's need to follow JCAHO recommendations, but I need to question the legality of denying Respiratory Therapists' their own access to respiratory medications in patients' cassettes. Is there a policy covering this issue in the Respiratory Care Practice Act?

*Response:* You have the right to be concerned with this change as a delay in respiratory treatment can cause extended length of stays and other adverse outcomes. I would hope that your facility has fully evaluated this process and understands the ramifications it may cause to patient care.

At my facility, we have also instituted a similar policy, but therapists are allowed access to the medication dispensing cabinet. To meet the JCAHO regulation, we have incorporated specific rights for the respiratory practitioners that prevent them from having access to medications they would not normally administer. Additionally, we have an automated report that will show us any medications dispensed by RCPs that are outside of their standard practice. That will allow for timely and appropriate follow-up.

From a practice standpoint, all you can do as professionals is document appropriately the delays that occur as a result of this change in process. Over time, this should provide regulators with sufficient clinical documentation to allow some flexibility in these regulations.

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*Inquiry:* I understand that a non-licensed person can set up a CPAP provided there is no instruction for "the purpose of deriving the intended medical benefit." My question is about the subsequent responsibilities of the respiratory therapist. Most home care companies require that an RT either call or see the patient within 24-72 hours following instruction by a non-licensed person. Due to the current shortage, sometimes only a phone call is done. Is a phone call adequate? Who determines this?

Also, must a home care company have a medical director, or is it the RCB that states that an RT must work under the supervision of a medical director at all times? What if there is no medical director?

*Response:* In terms of patient safety, I think a phone call does little to provide patients with the intended expertise a respiratory practitioner can provide to ensure a clear understanding of the therapy their physician has ordered for them. Your question regarding medical direction can be answered as follows:

Respiratory Practitioners must have a signed order from a licensed physician to administer care. Business and Professions Code § 3702. states, "Practice of respiratory care; Respiratory care as a practice means a health care profession employed under the supervision of a medical director in the therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities which affect the pulmonary system and associated aspects of cardiopulmonary and other systems functions, and includes all of the following: …"

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*Inquiry:* With the advent of the Power Ox program, home care companies now can legally facilitate pulse oximetry testing on their own patients. The oximeter is delivered by the home care employee. The oximeter is then applied by the patient, and the data is downloaded in a specially encrypted palm and then uploaded to the laboratory for analysis and reporting. The concept has been sanctioned by Medicare as being kosher. Does the employee downloading the oximetry data from the oximeter to the palm have to be an RCP?

*Response:* Based upon the information you have provided, it appears that the ONLY role of the home care employee with Power Ox is to deliver and retrieve the recording device. Based upon this information, it would be acceptable for the home care employee to perform this function.

I would clarify that the analysis and reporting of the information should be performed by a licensed respiratory care practitioner. The oximetry data collected is considered respiratory diagnostic care and therefore must be performed by a licensed practitioner.

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*Inquiry:* I am inquiring about being a discharge planner. Right now the job is being done by LVNs and RNs, and they are thinking of training me, but we are all unclear as to what my scope of practice covers (i.e. taking and writing physicians orders for DME). What does my license cover me to do in this area? Can I take an order for a wheelchair, a bedside commode, transportation via ambulance or whatever? What will it NOT cover?

*Response:* From a discharge planning perspective, there are no aspects of that job that would be excluded by the Practice Act for a respiratory practitioner. I would commend your facility and your administration for being forward thinking and proactive by including an RCP as part of their discharge planning team. I believe your expertise blends very nicely with the role of the RNs in that department and should prove to be a nice compliment to the patients you all will serve.

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*Inquiry:* I am writing to you regarding the RCP Role as an ECMO Specialist and/or Primer. I work at a children's hospital and would like to know where the RCB stands on this issue regarding our scope of practice. I understand that Section 3701 provides for the "existence of overlapping functions" and Section 3702 provides that an RCP is able to administer pharmacological

. . . CONTINUED ON PAGE 12

## Scope of Practice Inquiries and Responses (CONTINUED FROM PAGE 11)

agents as long as they are under a protocol approved by the hospital and its governing bodies. Please let me know if there are other resources I can utilize as reference. Thank you.

*Response:* The role of the RCP as it relates to ECMO continues to be somewhat undefined despite the fact that the function it provides is predominately cardiopulmonary in nature. I am not aware of additional resources that would answer your questions regarding ECMO. I would recommend keeping in close contact with the AARC as they research and document this treatment modality.

From a patient safety perspective, I would encourage you to keep your patients as your primary focus when your facility ponders its direction or decisions with regards to ECMO. Professionally, I believe the RCP is the best practitioner to deliver this modality in the acute care setting based upon both their education and training.

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*Inquiry:* I have been a licensed RCP in CA for the past 15 years, and I am about to change jobs. I am considering accepting a position in a subacute facility, but I am rather uncomfortable with a specific facility because they schedule 1 RCP for every 12 vent-dependant patients. This is in addition to trach care, breathing treatments, and circuit changes. I do not want to jeopardize my license with taking such an excessive load and frankly, some patients will be neglected. How often should vents be checked in a subacute facility, and how many vents can one therapist be reasonably accountable for?

The AARC guideline specifies neither quantity nor frequency. However, it does stipulate that a thorough vent check be done when there is a change in patient status, order, or interruption of circuitry. Can you assist me in finding what is safe for the patient as well as protecting my license?

*Response:* I wish I had a specific law or regulation to cite that you could reasonably use to make an informed decision about a change in your employment. Unfortunately, I do not. The laws and regulations surrounding appropriate staffing for RCP caring for patients on ventilators are far from adequate. Neither the Department of Health Services nor the California medical associations have the answer to your question.

From a professional aspect I would encourage you to review the organizations policies and procedures to see if their philosophy fits in with what you would feel comfortable doing professionally. If their policies do not match your professional values than you may want to reconsider this position.

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*Inquiry:* As part of Clinical Verbal Assessment in the disease management, can RCPs do "Breath Sounds," "Heart Rate," "Resp. Rate," and "Pallor" in home care without a doctor's order?

*Response:* It is definitely within the scope of a licensed respiratory care practitioner to perform physical assessments on patients in order to determine their baselines, or progress of ordered treatment modalities or care plans. Data gathering is an essential part of our work and is required to make informed decisions about patient care.

To further improve this concept, I would encourage you and your department to develop specific disease management protocols that allow practitioners to respond therapeutically to defined clinical indicators in order to avoid delayed patient care when a physician is not readily available. This approach is well documented in many clinical studies as the preferred method for improving patient outcomes and care.

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*The above determinations do not constitute declaratory decisions under the comprehensive provisions of Government Code sections 11465.10 - 11465.70.*

## Scope of Practice on the Web

A compilation of scope of practice inquiries and responses over the last two + years are also available on the Board's website at: http://www.rcb.ca.gov/

Once at this site, select the "Scope of Practice" link on the left side of the home page. Inquiries and responses may be selected by date or by subject.

## Satisfaction Survey

We want your feedback. Please visit our website at: www.rcb.ca.gov and complete our on-line Satisfaction Survey.

# Respiratory Care Affiliated Resources: Functions and Contact Information

## Respiratory Care Board of California (RCB)

The RCB is the state licensing agency mandated to protect and serve consumers by administering and enforcing the Respiratory Care Practice Act and its regulations in the interest of the safe practice of respiratory care.

Contact Information:
444 North 3rd Street, Suite 270, Sacramento, CA 95814
Telephone: (916) 323-9983 / Toll-free: (866) 375-0386
Website: www.rcb.ca.gov / E-mail: rcbinfo@dca.ca.gov

## National Board for Respiratory Care (NBRC)

The NBRC is a voluntary health certifying board which was created in 1960 to evaluate the professional competence of respiratory therapists. The NBRC strives for excellence in providing credentialing examinations and associated services to the respiratory care community. The NBRC offers the following credentials:

Certified Respiratory Therapist (CRT)
Registered Respiratory Therapist (RRT)
Certified Pulmonary Function Technologist (CPFT)
Registered Pulmonary Function Technologist (RPFT)
Neonatal/Pediatric Respiratory Care Specialist (NPS)

Contact Information:
8310 Nieman Road, Lenexa, Kansas 66214
Telephone: (913) 599-4200
Website: www.nbrc.org / E-mail: NBRC-info@nbrc.org

## California Society for Respiratory Care (CSRC)

The CSRC is an affiliate of the American Association of Respiratory Care and a non-profit professional organization. The CSRC's mission is to represent and encourage excellence in the art and science of cardiopulmonary support. The CSRC is committed to health, healing, and disease prevention in the California community and promotes this values to its members, students, healthcare professionals, and the public, through education and clinical practice.

Contact Information:
1961 Main Street, Suite 246, Watsonville, CA 95076
Telephone: (831) 763-2772 / Toll-free (888) 730-2772
Website: www.csrc.org / E-mail: webmaster@csrc.org

## American Association for Respiratory Care (AARC)

The AARC is the leading national and international professional association for respiratory care. The AARC encourages and promotes professional excellence, advances the science and practice of respiratory care, and serves as an advocate for patients, their families, the public, the profession and the respiratory therapist.

Contact Information
9425 N. MacArthur Blvd., Suite 100, Irving, TX 75063
Telephone: (972) 243-2272
Website: www.aarc.org / E-mail: info@aarc.org

## We Want Your Photos!

What kind of photos are we looking for? Anything and everything related to the practice of respiratory care! Why do we want these photos? For use in future Board publications such as newsletters, reports and consumer brochures. So please send them in! All respiratory-related photos are acceptable and can be submitted in the traditional format taken with a standard film camera or on a CD if they are from a digital camera.

Any photograph you submit to the Board is considered personal information and cannot be released to the public without your written consent. Accordingly, please provide a signed release for every person in the photograph including any patient(s) or co-worker(s) pictured. The release should state:

I, _____, voluntarily consent to the Respiratory Care Board using my photograph in its newsletters, reports, brochures and other related news publications. I understand that my consent will remain in effect until such time that I inform the Board in writing that it has been revoked.

Signature _____ Date _____

For information on submitting materials electronically, please contact Jennifer Mercado at (916) 323-9983 or via e-mail at rcbinfo@dca.ca.gov.

## Notice on Collection of Personal Information

The Respiratory Care Board of California of the Department of Consumer Affairs collects personal information requested on many of its forms as authorized by Sections 30 and 3730 of the Business and Professions Code. The Board uses this information principally to 1) identify and evaluate applicants for licensure, 2) issue and renew licenses, 3) enforce licensing standards set by law and regulation, and 4) collect outstanding costs ordered in final decisions resulting from enforcement action.

**Mandatory Submission.** Submission of the requested information is mandatory. The Board cannot consider your application for licensure or renewal unless you provide all of the requested information.

**Access to Personal Information.** You may review the records maintained by the Board that contain your personal information, as permitted by the Information Practices Act. See below for contact information.

**Possible Disclosure of Personal Information.** We make every effort to protect the personal information you provide us. The information you provide, however, may be disclosed in the following circumstances:

- In response to a Public Records Act request (Government Code Section 6250 and following), as allowed by the Information Practices Act (Civil Code Section 1798 and following);
- To another government agency as required by state or federal law; or
- In response to a court or administrative order, a subpoena, or a search warrant.

**Address of Record.** Please be advised that your address of record is not considered personal information and may be disclosed to the public. However, the Board will attempt to notify a licensed Respiratory Care Practitioner prior to releasing an address of record (if it appears the address may be a home address).

**Contact Information.** For questions about this notice or access to your records, you may contact the Respiratory Care Board at 444 North 3rd Street, Suite 270, Sacramento, CA 95814; Toll-free: (866) 375-0386, or e-mail: rcbinfo@dca.ca.gov. For questions about the Department of Consumer Affairs' privacy policy or the Information Practices Act, you may contact the Office of Privacy Protection in the Department of Consumer Affairs, 400 R Street, Sacramento, CA 95814, (866) 785-9663 or e-mail privacy@dca.ca.gov.

## Scholarships

The Board's website currently includes a page devoted to providing information about available scholarships.

The California Thoracic Society (CTS) often provides the Board with information regarding scholarships they offer to new and first year respiratory therapy students. When notified of these opportunities, the Board updates the CTS scholarship information on its website and publishes the information in its newsletter whenever publication and filing deadlines do not conflict. For more information regarding available CTS scholarships, please visit their website at www.thoracic.org/chapters/california.

If you are aware of any other available scholarship, please let us know so we can include it on our website and in our newsletters.

## Lung Health Day October 26, 2005

## Policy on Nondiscrimination on the Basis of Disability and Equal Employment Opportunity Statement

The Respiratory Care Board of California does not discriminate on the basis of disability in employment or in the admission and access to its programs or activities. The Executive Officer of the Board has been designated to coordinate and carry out this agency's compliance with the nondiscrimination requirements of Title II of the Americans with Disabilities Act (ADA). Information concerning the provisions of the ADA, and the rights provided thereunder, are available from the ADA Coordinator.

# Disciplinary Actions
## January 1, 2005 - June 30, 2005

### FINAL DECISIONS

**REVOKED OR SURRENDERED**
Barr, Beth, RCP 23431
Blakley, Amy Rae, RCP 20753
Bolivar, Raymundo, RCP 19262
Byers, Angela, RCP 14926
Penaranda, Carlos G., RCP 12459
Traudt, Mark P., RCP 11043

**PLACED ON PROBATION/ CONDITIONAL LICENSE**
Bonelli-Helms, Savina., RCP 5455
Garcia, Nicolas Joseph, RCP 24236
Garza, Hector Lira Jr., RCP 16332
Gist, Mary Ann, RCP 21334
Holcombe, Marci C., RCP 24332
Kidanu, Teka Teferra, RCP 15066
Lopez, Domingo F., RCP 24281
Mena, Antonio, RCP 17277
Orozco, Fidel Jr., RCP 13067
Raymundo, Fernando Jr., RCP 19595
Resurreccion, Jamie J., RCP 22742
Romero, Roger David, RCP 1988
Rowen, Timothy William, RCP 8018
Sherrill, Patricia Dawn RCP 7935
Smith, Steven Anthony, RCP 24213
Unutoa, Irene, RCP 9267
Unutoa, James Scott, RCP 24261
Young, Jeffery Keith, RCP 1701

**PUBLIC REPRIMANDS**
Cering, Sara W., RCP 18502
Drakakis, Alex Nick, RCP 21299
Gomez, Christina M., RCP 3296
Jones, Arlene A., RCP 7989
Okabe, Michael Alan, RCP 6734
Price, Patricia Louise, RCP 8495
Stanich, Cliff Mark, RCP 9093
Thomasson, Michael S., RCP 16785
Turner, Sean Patrick, RCP 13643

**CITATIONS & FINES**
Adame, Sonya S., RCP 13315
Anshutz, Ingrid M., RCP 4002
Arellano, Cynthia L., RCP 20195
Barnhart, Eileen Faye, RCP 15282
Bedolla, Sedrick Diego, RCP 22597
Bilson, Darla J., RCP 23693
Bomactao, Marc T., RCP 23260
Byrd, Monica Felice, RCP 23406
Capps, Lois A., RCP 6686
Coffey, Joe Jr., RCP 7223
Desilva, Asanka Harsha, RCP 21555
Duarte, Michelle M., RCP 8182
Ellington, Elizabeth A., RCP 17719
Ferrerosa, Jimmy, RCP 3369
Hendrix, Cindy Joelene, RCP 19386
Hennesey, Kelly DeeAnn, RCP 14691
Henson, Teresa J., RCP 4333
Horibe, Patricia Lynn, RCP 2531
Ledesma-Vasquez, Gilbert RCP 19173
Livengood, Mark Allen, RCP 23657
Macon, Gale Raeteena, RCP 3628
Malone, Connie Lee, RCP 7459
Marin, Fernando, RCP 22387
McDonel, Michael, RCP 18357
Perez, James G., RCP 18174
Perez, Richard, RCP 9335
Ranard, Christopher, RCP 20634
Simhachalam, John D., RCP 12640
Sion, Ronald L., RCP 21685
Skipworth, Sharyn Louise, RCP 2455
Soto, James, RCP 18464
Stansbury, David W., RCP 8584
Stark, Kimberly Jean, RCP 6645
Talamantes, Lawrence D., RCP 4704
Williams, Meachelle J., RCP 20370
Witmer, David M., RCP 20592
Wolfe, Lori Lynn, RCP 15685
Yanes, Carlos F., RCP 21024

**ACCUSATIONS FILED**
Anshutz, Ingrid aka Benham, RCP 4002
Bento, Michael Gregory, RCP 6523
Cacconie, Carl W., RCP 21206
Carrillo, Joseph Ernest, RCP 18493
Deschene, Tami L., RCP 18837
Girgis, Magdi F., RCP 17247
Hadley, Bryna Jea'Mar, RCP 19850
Hu, Ivy E., RCP 18822
Jordan, Shalesha L., RCP 21503
Kaufman, Lisa Ann, RCP 21444
Kreloff, Sofora Elizabeth, RCP 9704
Ligon, Beau G., RCP 18975
Ramirez, Geoffrey, RCP 21716
Webster, Joseph Dixon, RCP 19213

**ACCUSATIONS AND/OR PETITIONS TO REVOKE PROBATION**
Connel, Allan A., RCP 23512
Ivery, Lamont Otis, RCP 22791
Stupin, Elizabeth, RCP 6153

**STATEMENT OF ISSUES**
Sanchez, Edward James

To order copies of legal pleadings, please send a written request, including the respondent's name and license number (if applicable), to the Board's Sacramento office or e-mail address.

## Disciplinary Actions Definitions

**Final Decisions** become operative on the effective date, except in situations where a stay is ordered.

**An Accusation** is the legal document wherein the charge(s) and allegation(s) against a licensee are formally pled.

A **Statement of Issues** is the legal document wherein the charge(s) and allegation(s) against an applicant are formally pled.

An **Accusation and/or Petition to Revoke Probation** is filed when a licensee is charged with violating the terms or conditions of his or her probation and/or violations of the Respiratory Care Practice Act.

Respiratory Care Board of California
444 North 3rd Street, Suite 270
Sacramento, CA 95814

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Address Change Notification

Remember, you must notify the Board in writing if you have changed your address of record within 14 days of such change. Failure to do so could result in a $25 - $250 fine and delay your receipt of important materials.

Your written request must include your RCP number, your previous address, your new address, and your signature.

The Board office will accept requests received by U. S. Mail, faxed notifications and changes made via the Board's website.